A CHILD-to-child Handbook for India

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ABOUT THIS BOOK

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The United Nations declared 1979 "International Year of the Child". One of the ideas launched during that year was "CHILD-to-child", expressing the concept of an older child taking responsibility for the physical and mental development of younger ones. In November 1979, a group of teachers, paediatricians, educational administrators and community development workers from all parts of India, together with some of the originators of CHILD-to-child from overseas, met and talked for four days at the Niloufer Hospital, Hyderabad, about how the idea might be applied in India.

The concept itself is not new, of course; in most levels of our society, the older children in a family commonly look after the younger ones. What is new is the deliberate attempt to give the older child the skills to do that job better. In Hyderabad we discussed who could introduce CHILD-to-child and how; we listened to participants explaining how CHILD-to-child was working in their own districts, and considered how to publicise CHILD-to-child events. In the end we decided to produce a book to explain the CHILD-to-child concept, give examples of what some of us were already doing, and, above all, act as a practical guidebook for others wanting to experiment with CHILD-to-child activities but not sure how to proceed.

This is our book. It starts with an introduction by one of the earliest advocates of the CHILD-to-child philosophy, followed by 'case studies' of CHILD-to-child activities already in operation. Then come samples of 'activity sheets', with which teachers can put into practice various CHILD-to-child ideas. The last part of the book is a 'guide for action' distilled from the comments, suggestions and recommendations put forward by the Hyderabad workshop.

Further information on CHILD-to-child can be obtained from the CHILD-to-child National Committee whose secretary is:

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A CHILD-to-child HANDBOOK FOR INDIA

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at the
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at the
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Opinions expressed in the articles are the responsibility of the individual authors, not the editors.

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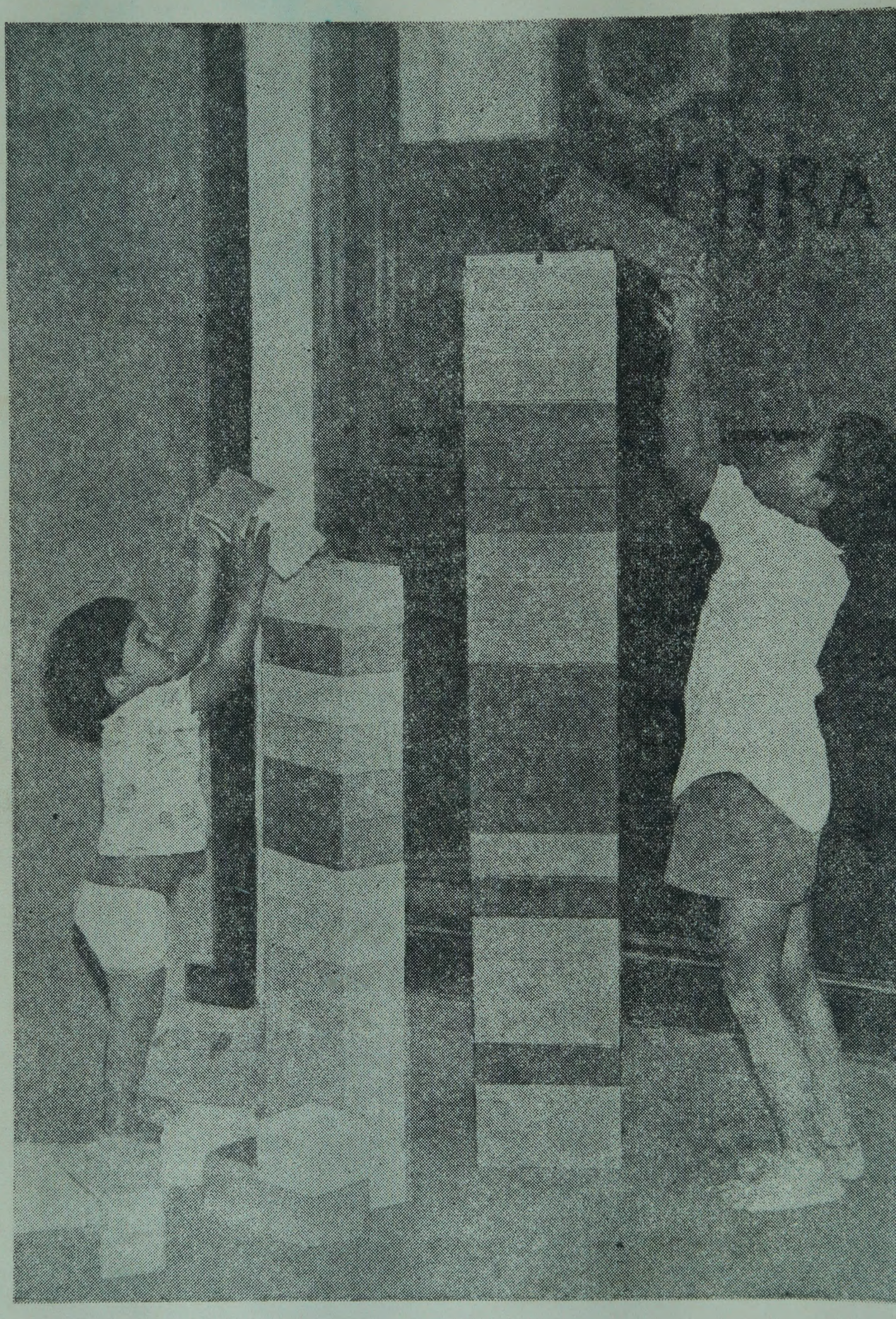

Illustrations : British Council-assisted children's projects in and around Madras.

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1 INTRODUCTION

The introduction to the book outlines how the CHILD-to-child idea came into being and what it means. The author has been closely associated with CHILD-to-child activities throughout the world, and took an active part in the Hyderabad seminar.

1

INTRODUCTION

The Development of the CHILD-to-child Concept

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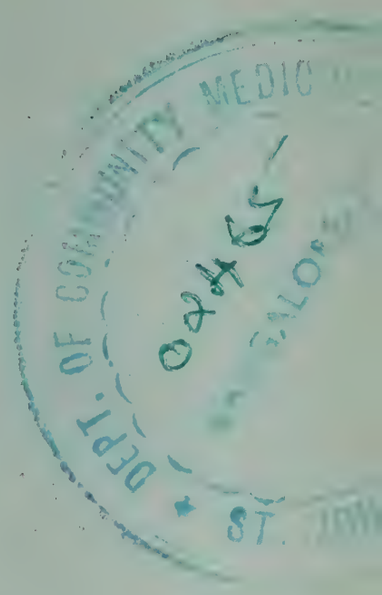

The far reaching decision of the Alma Ata Conference to bring primary health care to all mankind came as a result of many years of international discussion. Such a development presupposes a change in direction of the emphasis on health care and greater community involvement.

Equally in the field of education leaders and planners are seeking new approaches with more involvement of the school in communities. Particularly in rural areas emphasis in teaching has been to gain entry to secondary school and higher education, those who are successful being frequently lost to the rural or urban slum areas. Those areas where their skill and enthusiasm is needed are drained of their services.

The International Year of the Child in 1979 brought those in Education and Health together to launch the CHILD-to-child concept as a small contribution to more appropriate health and education services.

The design for this programme was first developed by the Institutes of Education and of Child Health of London University. The Ministry of Overseas Development of the UK Government responded in 1977 with financial support. After canvassing world-wide a workshop and conference were held in London and in Fittleworth in the UK in March 1978. At this conference small mixed groups of experienced educationalists and health workers discussed and developed the CHILD-to-child concept and the activities involved. As a direct result of this meeting an International Advisory Committee was formed. Also, and equally important, the results of the discussion were the production of the book

*'CHILD-to-child'** in time for the start of the International Year of the Child.

The concept of CHILD-to-child

The international meeting concluded there exists one untapped teaching resource—the primary school. "Primary schools are attended by many, sometimes most, of the children" stated the report of the meeting. "Primary school teachers are accepted as potential leaders and innovators, particularly in rural areas. Much goodwill exists towards the school. Despite its problems, the school remains a natural channel through which the health of the community can be improved with the children as the natural agents for change. No one could be better placed to be the change agent than the older child, already spending much out-of-school time with the smaller child".

This, examined more closely, is not a revolutionary idea. The report emphasises that older sisters already carry babies and care for them throughout most of the day, and that young toddlers are frequently left in the care of older children. Older children, it continues, help in several vital ways in the house, supervising hygiene, providing stimulation, playing with their brothers and sisters.

"They will perform these roles better if they understand them better, if the tasks are made easier and more enjoyable, and if they are given praise or encouragement". In other words, formalising something that has been practised for centuries all over the world. And this can best be done, concludes the report, by placing the CHILD-to-child concept firmly within a community setting, and giving it support from teachers, parents, health workers.

Bag of ideas

The meeting in 1978 described its recommendations as "not so much a package as a bag of ideas". Obviously, as its participants pointed out, the ideas will vary with

*Available in India from Macmillans, the Publishers.

the environment: rich nations will approach the question differently from the poor nations; rural areas differently from cities; older children will handle it differently from younger, and so on. But to turn this into a formal programme, involving everything from ministries down to village committees, means an immense amount of patient work. Political leaders, it continues, have to be involved to give a push from the top. Amongst the other "agents for change" are curriculum planners (who can ensure that the CHILD-to-child concept is built into formal school work), teachers and health workers, and of course the children themselves—whose ideas will be essential if they are to form the basis for the programme. Finally, the idea has to receive support in the media.

The report adds one warning: despite the close connection with formal school, the programme must also extend to the millions of children who never go to school—and thus adapt to "out-of-school children".

Developments during 1979

During the International Year of the Child the programme was launched in many countries. As was expected each country added its own particular flavour.

In Brazil it was accepted by the Ministry of Education and the books translated into Portuguese for wide distribution.

In Chile, with UNICEF assistance, a Spanish version was developed which, with Spanish activity sheets, are being used for a wide development throughout Latin America.

In West Africa a meeting of curriculum planners accepted the CHILD-to-child concept as a programme that would be willingly introduced and needed so few additional resources.

In East Africa a successful workshop in Nairobi saw the CHILD-to-child concept as particularly appropriate for their pre-school and early education programme.

In the Philippines the Medical Women's Federation accepted the CHILD-to-child programme to spread throughout their 40 Chapters.

In Indonesia the concept was found most appropriate and an energetic group had translated and appropriately illustrated a Basa Indonesian version before the end of the year.

In London an international workshop of writers prepared school readers incorporating the CHILD-to-child ideas as exciting stories.

Perhaps even more encouraging to the steering committee in London was the grass roots response from school and health units around the world. No two were alike. In Pune, children were out seeking signs of leprosy in other children and losing in the process the sense of stigma associated with the disease. In South Africa schools competed in preparing songs for smaller children, the best being broadcast on local radio.

In Mexico a school produced from bottle-tops and beer cans spoons to measure the salt and sugar for the rehydration drinks. In Indonesia games were developed which, if played at dusk, would reveal small children suffering from night blindness due to Vitamin A deficiencies. The variations and innovations seemed inexhaustible.

Problems to be overcome

As the programme developed, some difficulties were soon apparent. Although a new way of teaching rather than an extension of the curriculum, CHILD-to-child along with other such programmes for health is not an examination subject and so is not of 'high prestige'. However, this may be overcome by the series of readers since language is a priority subject. In many countries Health and Education departments do not easily work together. However, bringing them together for this programme may be one of its great assets.

The future

CHILD-to-child was launched in the International Year of the Child. It will now depend on continuing enthusiasm if the great potential of the older child in caring for the younger child is to be exploited.

CASE STUDIES 2

The bulk of this part of the book is taken up with a number of case studies. As it is essential to know about the background against which CHILD-to-child activities can be planned, the first two articles set the scene : one deals with present child-care facilities in an urban setting—Calcutta—and the second describes an increasingly common rural situation—a village community health programme coordinated from the local Medical School, in this case at Chandigarh.

The remaining case studies describe different sorts of CHILD-to-child schemes already in action. Another Medical School, at Hubli, concentrates its CHILD-to-child activities on a rural primary school, using medical students attached to a long-standing family welfare programme in the village. The same Medical School uses long-stay child patients in its own Paediatric wards to help care for younger patients in the wards.

The next, brief, study is of an urban scheme, in Hyderabad. It illustrates one essential ingredient in successful

CHILD-to-child programmes—close cooperation between doctors and teachers, those who have the knowledge and those who are skilled in communicating it to children.

An account of another urban scheme, in Tirupati, follows. Here is an attempt to contact school drop-outs, who are particularly difficult to reach by conventional methods, but who learn much from other children. Notice also the extent to which CHILD-to-child activities fit into pre-existing Government schemes.

Finally, as a contrast, a teacher-trainer involved with the development of CHILD-to-child ideas and coauthor of the international *CHILD-to-child* book, outlines how she developed a CHILD-to-child programme in Papua New Guinea, a country with some of the same problems as India.

Health Care Facilities for Children of Calcutta Slums

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Let us take the opportunity to take a close look at the health care delivery system to over a million children in a city, with its slums, shanty towns, crimes and delinquency. The city is Calcutta, the biggest in India by virtue of its population. It is also the city of greatest contrast and diversity. The richest of the rich stays here side by side with the poorest of the poor; the latest limousines dodge through the crowds of rickshaws and handcarts in the city streets. Only in recent years has attention been given to the deprived class. Various projects and plans are drawn up to meet the need of the under-privileged, but the magnitude of the problem is so vast that all the attempts appear to be too meagre.

The city

The city proper (Corporation area) is 104 Sq Km and the population is estimated to be 37,00,000. It is difficult, however, to say where the city ends. It does not. It extends to nearly 15 times the area (Metropolitan area—1373 Sq Km) and embraces, unlovingly though, more than three times the population (Metropolitan area—estimated population over 10 million). There are no reliable data to estimate the areas of slums and shanty towns. They are all over the city, newly-born and ever growing but not dying out. The total number of registered slums under the Calcutta Corporation are 2284 (1971 data). More than one-third of the city population stay in slums, and in addition there is a huge load of pavement dwellers, estimated to be a minimum number of 0.1 million in the Corporation area.

The target population

Children upto the age of 12 constitute 30-32% of population in Calcutta. So there are in the city alone at least 4,20,000 children in the largest group, the under-twelves living in slums or on pavements. Of these, nearly half are under two years of age.

The problem

The problems are so many that is itself a problem to identify all the problems related to health care delivery to the children under discussion. Certain features found mainly in cities are : a colossal number of children, poor health orientation and consciousness of parents and guardians, continuous rural-to-urban and interstate inflow, a mobile population (shifting to worse areas depending on the load of poverty), a high incidence of school dropout and adolescent delinquency in an environment of crime and deprivation, and lack of statistical data on various aspects of life of the target children, their environment, parental attitude and morbidity.

The helping hands of existing agencies

Up till now there is no Master Plan to deliver health care facilities uniformly and continuously to all children in the target groups. Isolated and non-coordinated attempts are being made by the Government and various non-government agencies to strike at the heart of the problem. The various agencies are : Government (State and Central), Calcutta Metropolitan Development Authority (CMDA), civic bodies (Calcutta Corporation, Urban Municipalities), international organisations (Red Cross, CARE, Oxfam, etc), voluntary agencies (Rotary, Lions, Masons, etc), charitable trusts, missionaries of all religions and individual workers.

Types of health care facility

Attempts to provide various facilities are made by different agencies in scattered areas. They are of three kinds : (a) Curative, (b) Preventive and Promotive, (c) Comprehensive.

(a) *Curative :* So far clinic-based curative medicine has been the common trend. The major portion of budget and resources are flowing through this channel with uncertain and doubtful cost-effect benefit.

No data are available on the number of children of the target group admitted to the free beds and getting free outpatient treatment in different institutions of the city. But it is beyond doubt that they are the major beneficiaries of the free curative services.

Curative facilities are provided as shown below :

TABLE 1

Curative facilities	
Hospitals	Government
	Charitable organisation
	Private
Dispensaries	Government
	Municipal—21 dispensaries in the Corporation area
	CMDA—7 urban health units, 37 static dispensaries, four polyclinics
	Charitable
	Private
Mobile clinics	Government
	CMDA—20 vans each cover 18 spots, once a week
	Charitable
Urban Health Centres	Nine of them
Health camps	Sporadic
Individual doctors	Allopathic and other systems, free and pay clinics

(b) *Preventive and Promotive :* These aspects are gaining importance day by day. The coverage is very limited in the target group due to lack of motivation, health consciousness and health education, lack of funds and wrong selection of priorities by authorities. The available facilities are summarised in Table 2 below :

TABLE 2

Prevention measures	
Clinics	Hospital Family Welfare Clinics, and Well Baby Clinics
	Urban Health Clinics
Immunisation programmes	Corporation—33 immunisation booths
	Hospitals—preventive medicine departments immunisation service
	Corporation—epidemic control measures
	Voluntary agencies
Nutrition	Corporation—40 milk kitchens serve $\frac{1}{4}$ litre free milk to each slum child under two years
	Voluntary agencies—nutrition supplements
Education and publicity	Schools—school health programme covers 50,000 school-age children in 250 Corporation schools
	Corporation—one publicity van with health educators
	Voluntary agencies

(c) *Comprehensive Health Care:* This is the latest addition to the health care delivery system. Presently nine units are working amongst the target population in different parts of the Metropolitan area of Calcutta. But the coverage is only a very small fraction of the requirement. There is one Urban Health Centre at Chetla, one associated with the Integrated Child Development Scheme Urban Project, Kidderpore and seven as part of CMDA Pilot Projects. These centres provide an integrated comprehensive health care system; there is a high financial input and trained manpower is available. These are the only bright spots in the vast darkness.

Future plans

CMDA wishes to improve environmental sanitation on a mass scale and establish a network of urban health units (one unit serving 12,000 population, mostly the deprived section, through comprehensive health care approach by female and male multipurpose health workers with clinic facilities and effective referral system).

The Corporation has a Bustee Improvement Scheme—a 15 million Rupee project particularly concerned with environmental sanitation. It plans to establish ward clinics in each corporation ward and 21 zonal dispensaries with out-patient departments, diagnostic facilities and referral arrangements. It also wants to extend Maternal and Child Health and Child Welfare services to reach the target more effectively, expand and maintain an effective school health service covering children in Corporation schools and embark on a massive triple antigen immunisation campaign for the under-fives.

The deficiencies we find in the present health care system are : lack of coordination among the various agencies, absence of central organisation, no definite planning, no estimation of cost-effectiveness and cost-benefit of the projects, poor documentation, poor or no motivation of people, lack of scope for exchange of ideas and views of each other involved in the job, no attention to the permanent

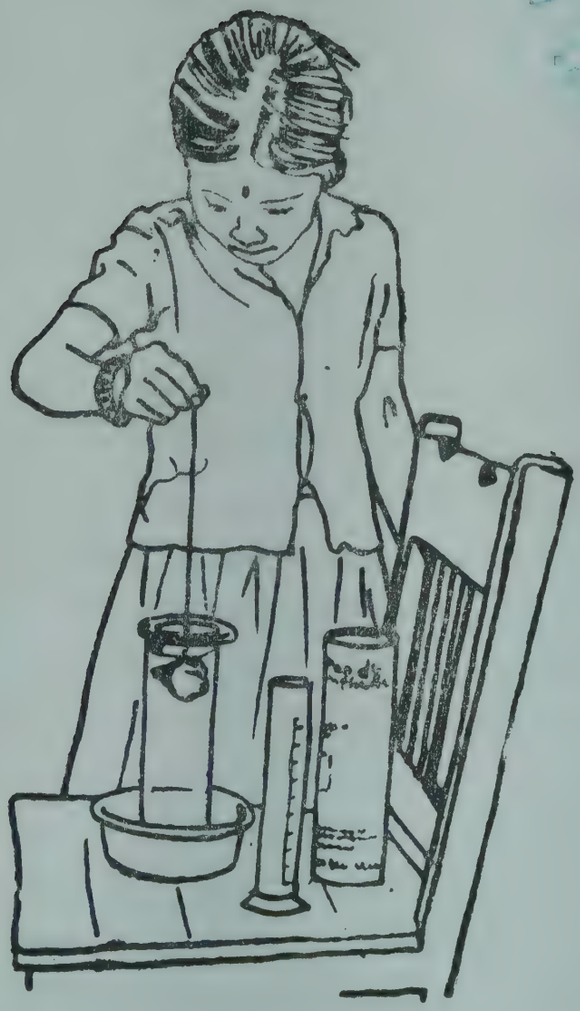
solution of childhood delinquency and problems of dropouts, wrong priorities, (ie. more budget for the curative aspects) and lastly no change of the stereotyped attitude of medical profession.

The crux of the problem is really the extremely poor documentation in the majority of cases. Hence the data collected are either inaccurate or not available at all. Therefore the cost-benefit and cost-effectiveness cannot be correctly estimated. The cost-benefit and effectiveness collected from the data available from the Chetla Health Centre and the ICDS programme have already shown the need of colossal manpower and economic resources for such projects. For any developing country such as ours, this kind of project though ideal is really very costly. Various alternative approaches to solve this major problem have been postulated to overcome the economic and manpower deficiencies in the developing world and one of them is the present CHILD-to-child programme. The implementation of this programme will have to be modified according to the local needs and the background.

The majority of the slum children attend the free primary schools provided by the Corporation from the ages of six to eight but the number of dropouts increases suddenly after the age of nine or ten as the majority of them get actively involved in the money-earning jobs, either legal or illegal. These children, when they are in the school are the ideal subjects for the CHILD-to-child programme. In this programme they will not only have to be motivated against diseases and illnesses but also will have to be motivated against delinquency and illegal ways of life. To our mind a CHILD-to-child programme based in primary schools should not only safeguard young brains against ill health but should actively motivate them to live healthier and cleaner lives. They should be inspired to love each other, love their home, love their locality and love the city they live in.

Acknowledgement

The authors are deeply grateful for the kind help, active cooperation and guidance they received from Dr. Sitesh Roy, Head of the Department of Social and Preventive Medicine, NRS Medical College Hospital; Dr. B. Bhattachariya, Director, Medical Cell, CMDA; Dr. S. P. Mukhopadhyaya, Lecturer, Chetla Urban Health Centre; and Health Department of Calcutta Corporation.



Chandigarh Field Work—The Rural Health Services

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The Postgraduate Institute of Medical Education and Research, Chandigarh, has initiated a collaborative project with Haryana State in which a subdistrict hospital and three community developmennt blocks in rural areas were adopted in 1975. Postgraduate students from different disciplines live in the rural area; they strengthen and study the health care delivery system.

The various components of the project are :

(a) *Ongoing teaching of different health personnel.* At the village level, these include community health workers, traditional birth attendants (dais) and Angan Wadi workers. Additionally multi-purpose health workers, their supervisors and doctors at the Primary Health Centre are getting their orientation regularly. The teaching sessions are organised on a once-a-week or once-a-month basis from 20 teaching village clinics.

(b) *Design and field-testing of new training material and training techniques.* The training is situational with emphasis on skills, the content is communicated in the vernacular and whenever possible relevent Audiovisual aids are used. Emphasis is on designing of simple material comprising pictures only when it concerns communication with people who have not undergone any formal education.

(c) *Improvised technology.* Examples include :

— use of oral rehydration techiniques by 80 community health workers in the development block. These health workers are preparing a rehydration powder at a cost of 15 paise. The referral of patients with diarrhoea has remarkably reduced since intensification of the programme.

— disposable 'Dai Kits' for widespread use in 50 villages at a cost of 75 paise. The components of this kit include soap piece, razor blade, cord ties, antiseptic solution, cotton swabs and paper napkins.

— weighing machines and height measuring bamboo sticks for traditional birth attendants. They are colour-coded to help easy identification of high risk women and high risk new-born babies.

(d) *Simplified information system.* The monitoring is done by using self-monitoring techniques. Important information is summarised and displayed on a chart. This helps the health worker to identify deficiencies and strengthen the programme and institute corrective measures.

Simple weight cards for under fives with health education messages and different colours to signify different degrees of malnutrition are in use.

Pictorial cards are used to identify events related to maternal and child care when records concern illiterate health workers.

(e) *Referral system.* Interlinks 25 villages, sub-centres, Primary Health Centre, Sub-district hospital and PGIMER Chandigarh. 2000 patients use the two-way referral system for which appropriate cards have been designed.

The efforts in the project have helped in publication of two books on maternal and child health in the vernacular and a book to recognise danger signals in common illnesses. The

institution is attempting to create a strong base for the implementation of a CHILD-to-child programme as a part of its overall commitment of better child care. In this endeavour the institution plans to use multiple entry points. The health educator and project director often meet the block education officer, district education officer and the teachers, for example, at the teachers' meeting which is organised once a month. In health education classes, nine topics have been taught a total of more than 200 times. Topics cover dental care, nutrition, accident prevention, eye care and screening for visual defects, personal hygiene, the appropriate use of water. Evaluation of students given the same teaching session by the same teacher has shown that students perform equally well whether they were from Class IV or from Class IX. It is hoped that a consensus on a training programme and CHILD-to child programme will emerge for implementation. This is helping identification of motivated teachers. Another group who could participate in the CHILD-to-child programme would be Angan Wadi workers who are also being identified. They would help in stimulation and various health aspects of pre-school children and adult literacy programmes with mothers.

Lastly, volunteer school children could help the project staff in looking after the health of other children by preparing oral rehydration powders.

CHILD-to-child Programme in the International Year of the Child by the Department of Paediatrics and Preventive and Social Medicine, Karnatak Medical College, Hubli.

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In the year 1978 November, the staff members of the Departments of Paediatrics and Preventive and Social Medicine (PSM) had a meeting to discuss the implementation of the CHILD-to-child programme in their area. In the state of Karnataka, as in other states of our country, it is a common feature to see the older children taking care of the younger ones. Usually the elder sister is the one who is immediately concerned about the security and other protective measures for the younger siblings. During the following year the Departments of Paediatrics and PSM of Karnatak Medical College, Hubli, together carried out a programme of CHILD-to-child in the following areas :

(1) Rural area—Gambyapur village
(2) Semi-urban area—Old Hubli area
(3) Urban area—Hubli city, particularly in the KMC residential campus

As per the policy of the WHO, our attention was focussed most on the rural programme, ie. in the village of Gambyapur.

CHILD-to-child programme in the village of Gambyapur

Gambyapur is a tiny village with a population of 1449. There are a total of 681 children of which pre-school-aged children constitute 212 in number and school-aged children 467. The total number of families is 170. The size of the families on an average consists of more than six members including the parents. In this village the CHILD-to-child programme is implemented as a part of family welfare programme. The various personnel involved in this programme are :

(1) The staff members of the Deparments of Paediatrics and PSM
(2) Postgraduates of the Department of Paediatrics
(3) Final-year undergraduate students
(4) Health Educators, ANMs, Sanitary Inspectors
(5) School Teachers in the village
(6) Health Committee in the village consisting of informal leaders
(7) Members of Yuvakmandal

The involvement of final year undergraduate students in this CHILD-to-child programme is one of the important features. They visit the village area once a week with the staff of the Departments of Paediatrics and PSM. These students are each assigned two families in the village. They take a detalied history and record the observations regarding the family size and socio-economic condition, and they make a detailed analysis of their observations for implementing the CHILD-to-child programme.

In the beginning 15 children were chosen from the only school in the village; these children were imparted instructions regarding the improvement of sanitary conditions, personal hygienic measures etc. In turn they passed on the various things that they had learnt to their younger fellows in the school. The usual routine of the school gave plenty of scope for the introduction of CHILD-to-child ideas such as drinking safe and protected water, washing the hands after playing

and before eating, regularly bathing everyday, combing the hair, helping in preparing the mid-day meal, standing in the queue and taking food. Implementation was achieved through reading, writing, singing, story telling, group feeding and cultural activities like drama.

The teachers also cooperated in the best possible manner. They incorporated in their daily lessons instructions regarding nutrition, health education, personal hygiene, the importance of disciplined life and celebration of cultural festivals. The response of the teachers and the taught was highly encouraging and as a result of the programme, the villagers have started using the sanitary latrine provided for them.

Semi-urban and urban areas

In the semi-urban area of Old Hubli, a CHILD-to-child programme was implemented on similar lines, and in the urban area of Hubli, in the Rotary School, an attempt was made to inform children about hygiene and traffic safety through activities like playing. Interesting cartoon films and special radio programmes were found to be very appealing to the children. The teachers and parents were eager to participate in making this programme successful.

Coming to the achievements in our own campus under this programme, we have started a new scheme of training the chronically ill parents in the Paediatric ward, who in turn teach the younger age group including some orphan children hospitalised in the ward. These children, who hail from rural areas, are now able to read and write. They are fond of telling stories and jokes, and they pass on all that they have learnt to their younger friends. In the ward they are also helping in taking the weight and measurements of other child patients and they assist the house surgeons and staff nurses in distributing and administering oral fluids and electrolytes to the dehydrated children. Their performance in the cultural activities on Children's Day, the 14th November 1979, was something very fantastic and appealing to all the audience. Likewise, the KMC Ladies Club in the campus has been very effectively undertaking this programme of CHILD-to-child.

The staff and postgraduate students are exploring all possible avenues to implement this scheme.

Thus in the implementation of CHILD-to-child programme our experience are highly interesting and unique, and practically no difficulties as such were encountered. "Well begun is half done"—we intend to widen the CHILD-to child programme to larger and larger spheres, to promote child welfare, as the results are highly rewarding.

CHILD-to-child Programme in Hyderabad

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Two semi-urban schools have been chosen to organise some activities of CHILD-to-child programme. Both schools are located in the outskirts of Hyderabad city.

School children of St Xavier School were involved in an activity on "Balanced diet and preparation of foods".

The following steps were adopted :

1. Children collected various food items like cereals, pulses, nuts, green leafy vegetables, milk and curds, etc.—which combine to form a balanced diet.
2. Older children explained the value of each item in the diet of a child. The importance of energy foods, body building foods, vitamins, and minerals were explained to small children.
3. Children learnt how to wash the raw vegetables in clean water.
4. Rice cooking was demonstrated. The excess water (canjee) should not be thrown away. It can be used as a soup or porridge as it contains lot of Vitamin B_1. This aspect was emphasised.
5. How various items like rice, chapati, dosa, etc can be prepared were explained to them. They participated in the actual cooking.
6. Keeping the food clean, well covered and protecting from flies etc was demonstrated.

Children enjoyed this particular practical exercise and the younger ones asked quite a number of intelligent questions

regarding the distribution of prepard food spread over the entire day. They showed keen interest in further activities.

In another school a "Health Club" has been formed and school children were given demonstrations and lecturers in personal hygiene; dental care, care of the eyes, choosing the food, etc. Children were also actively involved in some of the activities.

At present the programme is still in an infant stage and the schools are organising the activity once in a way.

The programme is supervised by Dr Nagaraj Rao and the principals of the two schools.

CHILD-to-child Programme in Tirupati

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Tirupati in Andhra Pradesh is a town with a population of around 100,000. The population consists mostly of two types of people: employees of the Devasthanam and various educational institutions, and people dependent on the pilgrims who throng the town around the year. There are nearly 30 elementary schools run by the Municipality and Tirumala Tirupati Devasthanams. The children attending these schools mostly come from very low socioeconomic levels and deserve all the assistance they get in the educational, nutritional and health standards. The Government of Andhra Pradesh has selected this place as one of the three centres for the whole state for running the school health service programme. This programme is intended for medical inspection for all primary school children, diagnosis and treatment of minor ailments, detection and referral for the major ailments of school-going children.

Many of the children attending these schools live in very unhealthy surroundings, in unsatisfactory accommodation with inadequate toilet facilities and improper water supply. Under these conditions it is not surprising that many of them do not take a bath regularly, do not even brush their teeth

daily, spend most of their time absconding from schools and they become urchins on the streets. The younger children who are of pre-school age are neglected very much as the parents are busy earning their livelihood. Considering all these factors we decided during the International Year of the Child to launch the CHILD-to-child programme along with other centres in India and other countries.

A CHILD-to-child programme committee was formed consisting of a Paediatrician, School Health Medical Officers, teachers and some parents. On discussion we evolved a plan by which we trained 170 urban primary school teachers to detect minor ailments in children, to give health education and teach personal hygiene and prevention of accidents. The teacher training programme was carried out for a period of three months, on every Sunday between 9-00 and 11-00 am with Audiovisual aids. At the end of the training, certificates were issued to the teachers. Later the primary school children were trained by the school teachers.

These were some of the activities carried out :

1. *Detection of malnutrition by arm band :* Arm bands were supplied to the children by Parke-Davis Company. The children were first educated on the usage of the arm band to detect malnutrition in preschool children. Most of the primary school children evinced interest in this as the arm band looked like a toy for them. The school children detected 157 cases of malnutrition by this method and the malnourished children were brought by the parents to the Paediatric Department of SVRR Hospital. They were admitted and treated accordingly.

2. *Detection of vitamin deficiencies :* The school children were trained in detecting deficiencies of vitamins like A and B Complex with more stress on vitamin A deficiency detection. They were taught to detect and bring children with xerosis of conjunctiva and blindness for treatment. So far 91 and 96 cases of vitamin

A and B Complex deficiencies were detected respectively. A case of well advanced vitamin A deficiency with Keratomalacia and blindness was brought by a school child.

3. *Detection of some of the common conditions :* So far the school children have detected 143 cases of scabies. 43 cases of dental caries and 137 cases of pediculosis. The cases with scabies and pediculosis were given out-patient treatment in the Department of Paediatrics and dental caries cases were referred to Dental Department of SVRR Hospital.

4. *Scar Survey :* The school children were trained to detect BCG and smallpox scars and were asked to bring the preschool children in their locality, who were not having the scar, for immunisation. Thus far, in a period of nine months, 176 children for BCG vaccination and 15 children for smallpox primary vaccination were brought to hospital for immunisation.

In addition the teachers told the school children about the importance of combing the hair, cutting the nails, washing the hands and changing wet diapers of very young children. The teachers were asked to allot marks for the number of tasks done by a school child, as an incentive for the school children so that they will enthusiastically participate in the CHILD to-child programme.

After seeing the success of the CHILD-to-child programme in the urban area, we want to extend it to the rural areas gradually and we want to take up this as an on-going programme.

CHILD-to-child programme in urban slum areas where children never go to school

In the urban slum areas in and around Tirupati, a preliminary child health survey was done under the guidance of Dr Indira Bai, and it was found that most of the children were not attending the school at all. So those children were thought to be badly in need of the CHILD-to-child programme.

First, by repeated interviews and visits, a close contact and rapport were established. Then a morbidity survey was carried out and the children were treated by the visiting health team. Two intelligent children 10-12 years of age were selected in each slum area and were trained to recognise common diseases. They were asked to search in their respective localities for cases of dental caries, diarrhoea, vitamin A deficiency, vitamin B Complex deficiency, scabies, pediculosis, hearing defects, speech defects, pica, pot belly, cough, fever, physically handicapped children, worms in faeces and children with no vaccination scar, and to bring them to the notice of the visiting health team.

It was found out that many of them did brush their teeth and did even wash their faces every morning. A few of them were cleaning their teeth with charcoal powder, ash, brick powder or sand. They never bothered about a bath. Their parents usually get up at 5-00 am and after preparing the food for the day, hurriedly go off to work at a far-off place, only to return late in the night. Children in the house, thus left to themselves, never bother to clean their teeth or to have a bath. They play in dirt till they get hungry and eat whatever is in the utensils in the house. Naturally they never go to school.

Such children were gathered by the health team and were told in a convincing manner that they should clean their teeth regularly using neem sticks or soft toothbrushes, to prevent tooth decay and infections. They were advised to take a bath at least once in a day and to wash their clothes properly.

The selected leader of the area was given the responsibility of ensuring that every child in his area keeps itself clean. They were taught to take cheap food stuffs which were nutritionally good.

After the patient efforts of $2\frac{1}{2}$ months, the programme has yielded remarkable results. But the poverty of these children makes it difficult to believe that such a change for good is going to be maintained. The cases of children having only one dress (that too, ragged) cannot be expected to improve to the status of wearing washed clothes. Many of them cannot

afford to purchase a soap and to have a bath. We are convinced that improvement of economic status alone can sustain any improvement in the health and hygiene of a child brought about by such programmes.

Children cooperated very well with us and were intelligent enough to understand our teachings. What a pity that they are not attending school at all.

Difficulties encountered in the implementation of the programmes

Majority of school children are cooperative and we are happy about this. Some of the school children are not cooperative and enthusiastic. This is being tackled by patient and persistent efforts. Some of the teachers also lack full cooperation and interest.

Some of the cases of malnutrition detected could not be treated and followed up as the parents did not bring them for treatment due to poverty, ignorance, distance from the hospital or both parents being bread-winners of the family. This has to be tackled by forming parents organisations and educating them about the aims and importance of the programme. We want to distribute supplementary nutrition packets to malnourished children at their home when they are not brought to hospital by their parents.

Future plans

We want to involve local voluntary agencies like Lions Club, Rotary Club, TT Devasthanams for effective implementation of the programme. We want to extend this programme to rural areas with the hope that the rural folk will welcome this programme wholeheartedly. To lay out the more simple tasks to be done by the primary school children, the planning committee decided to hold discussions every week. To encourage the children to participate actively, we intend to award prizes as an incentive to the good candidate who achieves good results.

The teachers can be advised to participate in the programme by giving education and required information to

the children as a routine daily programme. We intend to rebrief the children every month with attractive posters and Audiovisual aids. We are planning domicillary treatment of sick children who are detected by primary school children and not brought to hospital. At the same time we are aiming to train the children in providing first aid measures like dressing wounds. We want to impress upon the students the importance of personal hygiene and environmental hygiene. We want to encourage them in activities like keeping the school clean and gardening. We wish to make them realise the importance of immunisation.

In rural areas where the Integrated Community Development Scheme is functioning we want to train the children to bring their younger siblings to the Anganwadi Centre to receive supplementary and therapeutic nutrition without fail. The Anganwadi worker will be stressed to tell the older children about the importance of locally available foods. The primary school child will be trained to popularise the importance of immunisation instead of hiding the younger siblings. We intend to stress the importance of personal hygiene through primary school child to the greatest possible extent.

A Case Study from Papua New Guinea

Ms Audrey Aarons
Faculty of Education
University of Papua New Guinea

This is the story of how in one country, Papua New Guinea, teachers and school children were involved in a CHILD-to-child programme. Papua New Guinea, a country of three million people, independent since 1973, lies off the North Coast of Australia. Like India, over 80% of its population is rural, depending largely on agriculture, and like India too, there is a multiplicity of languages (over 700 spoken) to add to the communication difficulties posed by the mountainous terrain.

The scale of the activity is vastly different from any Indian programme but the decisions that were made and the steps taken may be much more similar.

Introducing the CHILD-to-child programme

Introducing the CHILD-to-child programme to teachers in Papua New Guinea was assisted by coming at an *appropriate time :* the school health syllabus was under review; teachers' guides were being rewritten with the intention of involving older children in community health activities; and a nationwide nutrition campaign had been launched which included school lunch programmes and school food-garden projects.

Out of this concern for the health of children the Secretary for Education supported the CHILD-to-child programme by suggesting it be the focus of the Department of Education's contribution to the International Year of the Child. Having *official sanction* to carry out a programme gives credibility to those trying to involve teacher, school inspector and health worker.

COMMUNITY HEALTH CELL
Bangalore - 560 034

The time being appropriate and official sanction having been given, how then were teachers involved in the CHILD-to-child programme?

Presenting the CHILD-to-child approach to teachers

(a) *Preliminary trials :* The first step was to get together in 1978 a small group of interested teachers (pre-school, primary school, school-leave centre, vocational centre), youth club leaders (Girl Guides, Boy Scouts, Boys Brigade) and health educators, to explain the ideas. Each of them selected a CHILD-to-child activity to try out eg. school teachers took "Better Food", "Accidents"; Youth Club leaders took "Care of the Sick", "Play". After one month the curriculum officer and CHILD-to-child coordinator visited the different groups to find out how well the activities had been implemented.

Some lessons learnt from this brief trial were : that workshops needed to be held so that teachers and others had a chance to work out activities in a structured situation : that teachers needed support whilst putting the ideas into practice; and that primary school teachers were the ones able to implement the ideas with the least preparation.

Reports of these trials were written up and illustrated in the newspaper, education gazette and for the teachers radio programme. This public awareness endeavour was particularly useful for the next stage—developing the programme.

(b) *CHILD-to-child as a curriculum project :* Given the limited personnel available who were familiar with the CHILD-to-child concept (the curriculum officer and the CHILD-to-child coordinator), it was decided that the primary school teacher should be the target for the programme in 1979.

A group of 64 primary school teachers taking a university diploma course based on part university study, part correspondence work was an ideal group to begin with : they would have workshops during the university course and

carry out an activity during their period of field work when back at school. Their task was to select topics from the graded health syllabus and to teach these topics using a CHILD-to-child approach.

From this there came a large number of sample activities based on the school health syllabus. These will be edited and put into booklet form to be used at in-service sessions for other teachers. As a result of the involvement of these teachers it was decided to select two of the provinces in which these teachers were working and to monitor the progress of an extended CHILD-to-child programme.

In the Southern Highlands Province, provincial health officers and school inspectors, the head-teachers concerned and the curriculum officers held a three-day workshop. The health officers discussed the health needs and priorities of young children in the province, the teachers matched these to the topics in the health syllabus (there were many deficiencies in the syllabus !) and a two–term teaching programme was drawn up (see example below) :

Making a Teaching Plan

Step 1

Common Health Problems of Young Children in SHP	School Syllabus Topics
1. *Lung diseases* — influenza, colds, pneumonia	What is disease? Sickness of the lungs How do germs travel? Diseases of the lung
2. *Stomach problems* worms, diarrhoea	Clean water/food/hands Clean village Water and health Dirty habits
3. *Malnutrition*	etc.,

Step 2

A teaching sequence for diarrhoea

1. What is diarrhoea? Ask children what they know.
2. Organise a survey—who has had it? How many 0-5 year olds?
3. Discuss what children found out.
4. Teaching points about diarrhoea.
5. How to treat it: use experiments to show plants die without water; how bodies lose water and need it replaced. Learn to give fluids—record how often it's been done.
6. Talk about and make different fluids to use at home.
7. Learn to recognise danger signals.
8. How to prevent it. Clean hands, clean food, clean places.

One term's programme of ten weeks was given over to the subject of diarrhoea, as the health workers were about to mount a diarrhoea prevention and treatment compaign. Activities for the school programme were based on things children—firstly, should *know about* and *understand* (experiments were devised for such concepts as rehydration, fluid loss, importance of clean hands); secondly, could do to *inform others* (surveys, posters, plays) and thirdly, could learn to do to *help treat* young children (for example, through rehydration).

An evaluation sheet to be filled in each week shows how often teachers make contact with parents and health workers and how often children inform others or treat younger children.

When the teachers return for the next part of the university course they will make a report of their activities, make recommendations for extending the programme in 1980 and prepare teaching materials on topics they have taught, which will be made available to others.

Continuing to develop the CHILD-to-child programme

Plans to extend the CHILD-to-child programme in 1980 will include (i) the use of teachers from the various courses

(diploma, health enrichment, a total of more than 100) to become leaders at in-service workshops in the provinces, and (ii) the preparation of teachers' guides and materials at the curriculum unit of the Ministry of Education and at provincial level through curriculum panels.

Having established a framework for developing CHILD-to-child programmes in schools it will be time to diversify our resources towards the non-school child—a much more difficult group to contact!

Some lessons learnt from the experience

1. We have really only touched the tip of the iceberg—how many of the activities of the teachers and the children actually affect the health of the under-five child? We need to think of better ways to monitor this.
2. It is too easy for teachers to see the CHILD-to-child approach as an activity programme and forget the target—the under-fives. The health workers on the other hand tend to oversimplify the role of the older child as a change agent.
3. Beginning with a small motivated group in a structured situation helped refine the concept for each school situation; it helped provide support and supervision for what was being done at very little additional cost; it provided a core of carefully prepared teachers for expansion of the programme.
4. Materials and programmes were developed and can be used as examples by others.
5. The importance of communication: teachers need to plan with health workers, agriculturists and others so that community programmes and approaches match; teachers need to keep parents informed so that they do not feel threatened by children's "school ideas"; teachers need to share ideas with other teachers!

SAMPLE ACTIVITY SHEETS

3

One of the best ways of passing on successful ideas to interested colleagues, as the previous articles show, is through activity sheets on selected topics. Here are three activity sheets on common health problems, which have been used in CHILD-to-child programmes in Hyderabad.

1 Healthy Surroundings

Dr Michael Aranah

Aims

- To let children find out and understand that unclean surroundings at home, school and playground are harmful to their health.
- To let them discover in their areas, where ponds, puddles and dirty places are found, and encourage them to think about ways in which they can improve the situation. What are the existing local practices for disposal of waste? Are they good?

Who can organise

1. Primary school teachers — during the science lesson
2. Health workers — during visits to communities
3. Youth organisations or Mahila Mandals

Activities

- Ask children to make a survey and draw a map of the area in which they are living.
- Ask them to mark with red pencils the dangerous places in their area.
- What should be done to clear these dangerous places? Take children's ideas—discuss with them some simple remedies, such as cleaning the home surroundings and preventing collection of dirt (eg by removal of foot-wear before entering the house).
- Get them to wash their hands in a common bucket and observe how dirty the water becomes—Is it wise to drink such water?

— Show examples of what a cat does when it defecates — it digs a pit and covers it with mud. Ask children to dig small pits and bury waste material.

— A few weeks later—plant green leafy plants or seeds in the spot. Show them, that the waste acts as a good manure and helps the plants to grow well.

2 Cleanliness

Mrs A Ranganayakamma
Lecturer
State Council for Educational Research and Training
Hyderabad

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Aim

— To make the children understand that habits of cleanliness include covering the nose and mouth while sneezing or coughing and inculcate the same habit in their siblings and neighbouring children.

Activities

— Ask the children to bring handkerchiefs of their own to the school. Advise them to cover their nose and mouth whenever they sneeze and cough. Make them observe some dust particles on the handkerchiefs.

— Display pictures of surgeons and nurses covering their heads, mouths and noses with a piece of cloth in the hospital. Discuss with the children that covering their mouths and noses prevents the spread of bacteria to the patients.

— Ask the children to observe and report while they cough or sneeze in their palms.

— Make an inspection of the handkerchiefs and advise the children to use clean kerchiefs.

— Advise the children to turn to one side when they sneeze or cough in the presence of friends.

3 Balanced Diet

Dr M Nagaraj Rao
Assistant Professor in Paediatrics Research
Niloufer Hospital
Hyderabad

Aim

— To teach hygienic principles of food preparation and the need for a balanced diet in the healthy living.

Who can organise

1. Teachers of primary schools
2. Health workers

Activities

— Ask children to collect various types of raw foods required to prepare a balanced diet.

— Show them how to cook rice (eg the excess water in the pot should not be thrown—"canjee" can be given to small infants as it contains vitamins).

— Clean green leafy vegetables thoroughly in a dish or bowl of water before cooking—show the children the amount of dirt that collects in the bowl.

— Show them a diagram of eggs and adult worms and how they grow in intestines. Explain that if raw vegetables are consumed without washing, the eggs of many worms are likely to enter their stomach and intestines, and grow into adult worms and eat away all good food.

— Involve them in preparing a chapati.

— Show them how to assess the nutritional status of younger children with the help of an arm band or bangle.

— Get them to see how many in the class have vitamin A deficiency or B Complex deficiency.

GUIDE FOR ACTION 4

This chapter is designed primarily for individuals or groups who, perhaps stimulated by reading earlier parts of the book, would like to start CHILD-to-child activities. It does not claim to be either authoritative or exhaustive, but rather to indicate the various steps to be taken, points to be considered, decisions to be made and so on. It is divided into sections, corresponding roughly to the sequence of steps in planning and implementing a CHILD-to-child programme. It is compiled from the comments, suggestions and recommendations put forward by the Hyderabad seminar.

FIRST:

Find out about CHILD-to-child

You cannot organise a programme without knowing about the subject yourself.

You can

— read this book

— read the international book *"CHILD-to-child"* by Audrey Aarons and Hugh Hawes, with Juliet Gayton, published by Macmillans (distributed by them and by the Voluntary Health Association of India, C/14 Safdarjung Development Area, New Delhi 110 016, who may have some vernacular versions).

— contact the CHILD-to-child National Committee: the Secretary is Dr M Nagaraj Rao, Institute of Child Health, Niloufer Hospital, Red Hills, Hyderabad 500 004, Andhra Pradesh.

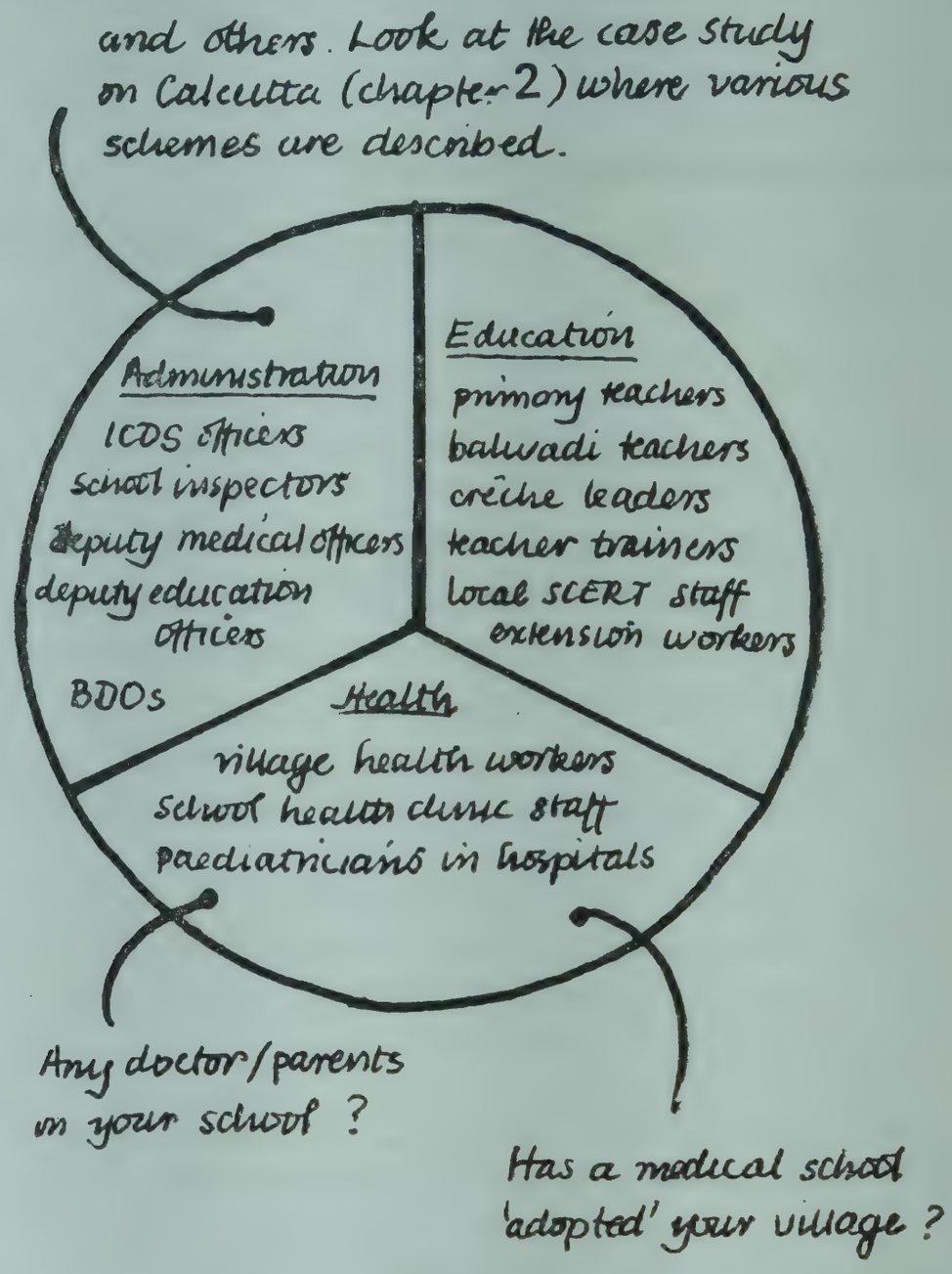
— look through the list of participants at the Hyderabad seminar (Chapter 5) for someone in your area and contact him or her.

NEXT:

Get to know your counterparts

* If your programme is to be effective, you must combine a correct knowledge of what to teach with skill in passing on that knowledge to children. This means that you need to collaborate with people whose abilities complement your own. If you plan to work within an established system of education or welfare, you will also need to know how the system is run and who runs it. Administrators can be approached in several ways—for example a Block Development Officer (BDO) can be contacted from above, by the state Rural Development Department or from below, by individual teachers.

* These are the people who can be involved :



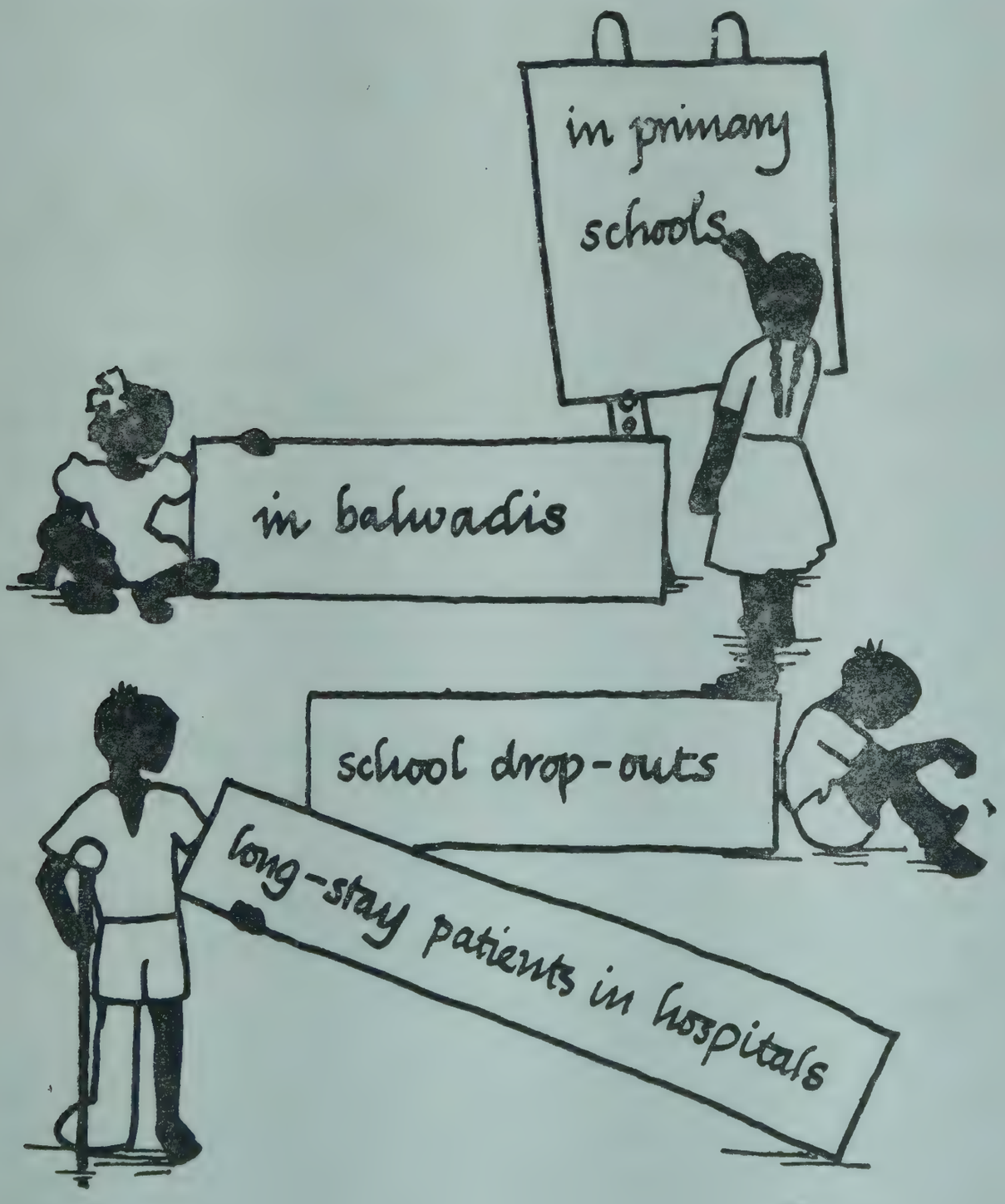
* The sort of organisations you can involve are :

— primary schools (especially school health schemes)
— balwadis
— balsevikas
— creches
— the educational technology cell in the state
— Ministries of Education, Social Welfare, Women and Child Welfare
— ICDS Centres
— teacher training colleges
— medical colleges
— primary health centres
— voluntary agencies

* Don't forget about the *informal* sector—Mahila Mandals, teachers' association centres, parent–teacher groups, Boy Scout troops.

* The children you are aiming to help are the under–fives. It is undoubtedly easiest to help through organised channels like schools, but the children most in need come from those families where no one goes to school; in some communities, even, teachers are associated with unpopular authority, because of their role in family planning campaigns and elections. Home visiting, as in the case study from Tirupati, (Chapter 2) or enlisting voluntary agencies, may be only possible solutions.

The children themselves could be :



THEN:

Decide what you want to do

Short of ideas?

— read the case studies and activity sheets in this book

— look for ideas in the international *"CHILD-to-child"* book

* Don't assume you will need large funds to carry out a project; the programmes described in the case studies took place side-by-side with other activities, without extra money being sanctioned. For the purchase of Audiovisual aids or toys, local voluntary groups might be willing to assist.

Children can be surprisingly resourceful and responsible, given the opportunity. They can:

Carry out surveys in their family or neighbourhood for cases requiring immunisation, sources of clean water, insect breeding grounds etc.

teach one another road safety and how to prevent accidents in the home

They can

detect signs of common illnesses; test other children's sight or hearing

make simple toys for other children; play with them

learn to diagnose infant diarrhoea and give a rehydration mixture

Look for signs of malnutrition, using for instance a graduated armband, and record the growth and development of younger children.

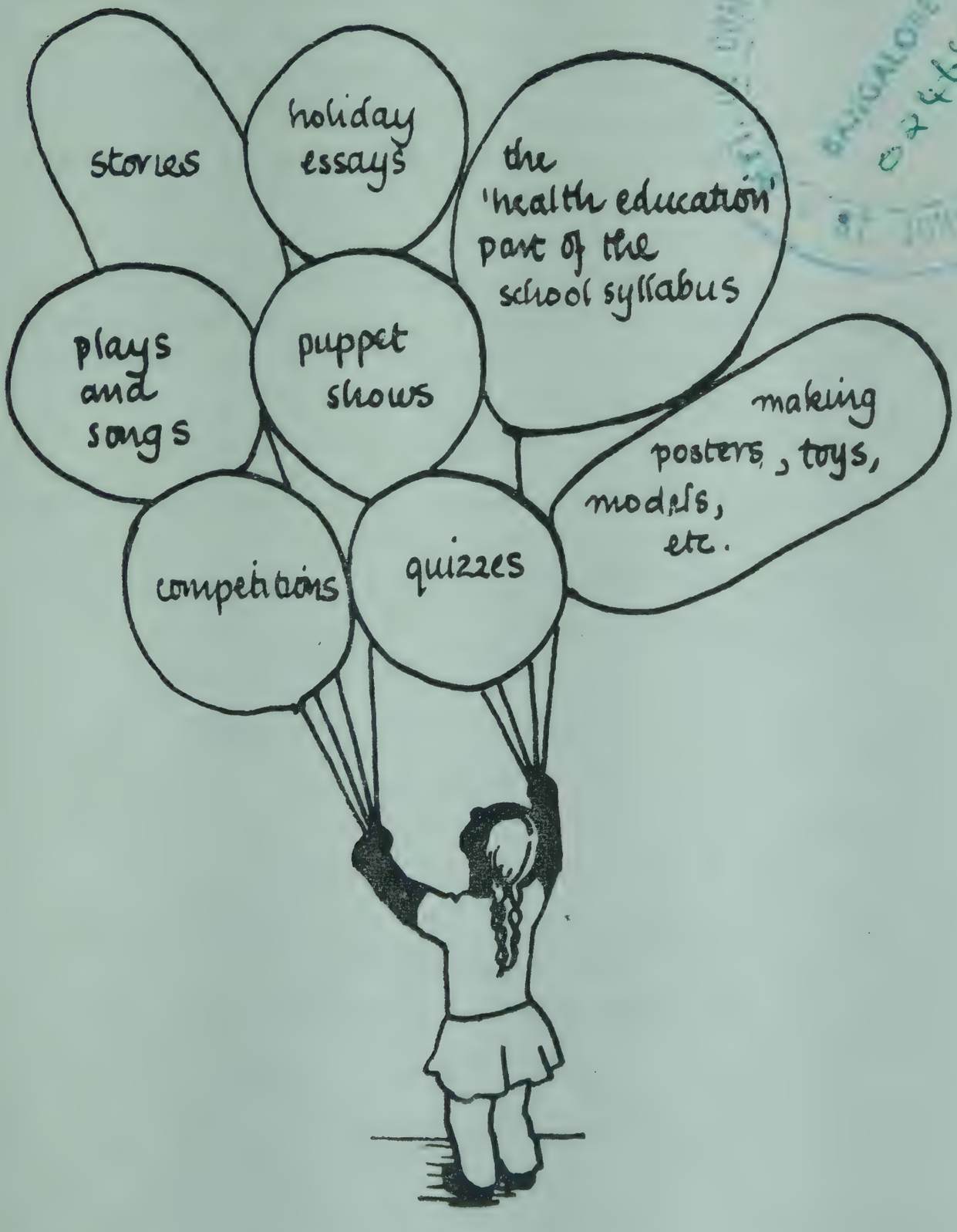
* One activity in which more experience is needed is the use of children to make community surveys of diseases like leprosy and TB. One medical school that had tried this (at Miraj, Maharashtra) felt it was promising, but it is not clear whether adults will take children seriously

enough to give them accurate answers, especially about diseases that carry some social stigma. It may be that the best method of collecting data is to ask children about their own household only, and for a community health worker to compile statistics.

* The older children, that is, the ones doing the teaching, would, normally be about 7th or 9th standard, but effective programmes have been run with children as young as 4th standard.

Plan your programme

Some of the 'vehicles' for CHILD-to-child activities are:



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* You may need to obtain permission from statutory bodies controlling education and health services for your programme. However, if you are working in collaboration with administrators as suggested earlier, this should present no problem.

* Think about rewarding successful participants with badges or certificates.

* If you are planning to train teachers, rather than teach children directly, you may perhaps hold workshops or seminars. Suppose, for example, that you want to hold an "orientation" course for primary school teachers (say the 4000 of them in Hyderabad). You decide you can give groups of 20 of them one two-hour teaching session in their own districts (costs are then very low because no stay and very little travelling is involved). You put a proposal to the Director of School Education, who then sends comments to district education officers. You establish a team of people—a child health specialist, an epidemiologist, perhaps, a language/communication expert—to chalk out a programme. You may decide on a pilot study on a small group, to iron out snags in the material.

* Think about the time-scale. Do you want to introduce CHILD-to-child activities gradually, say by slowly assimilating them into the school curriculum, or mount a short, intensive campaign?

FINALLY:

Publicise!

You have a successful CHILD-to-child programme?

Tell others about it:

— write a press release for the news agencies

— write a newspaper article

— write for a children's magazine

— write in health journals like Swasth Hind, Health for Millions, Medical Times

— write an article in your organisation's newsletter

— translate the international *"CHILD-to-child"* book into a vernacular language

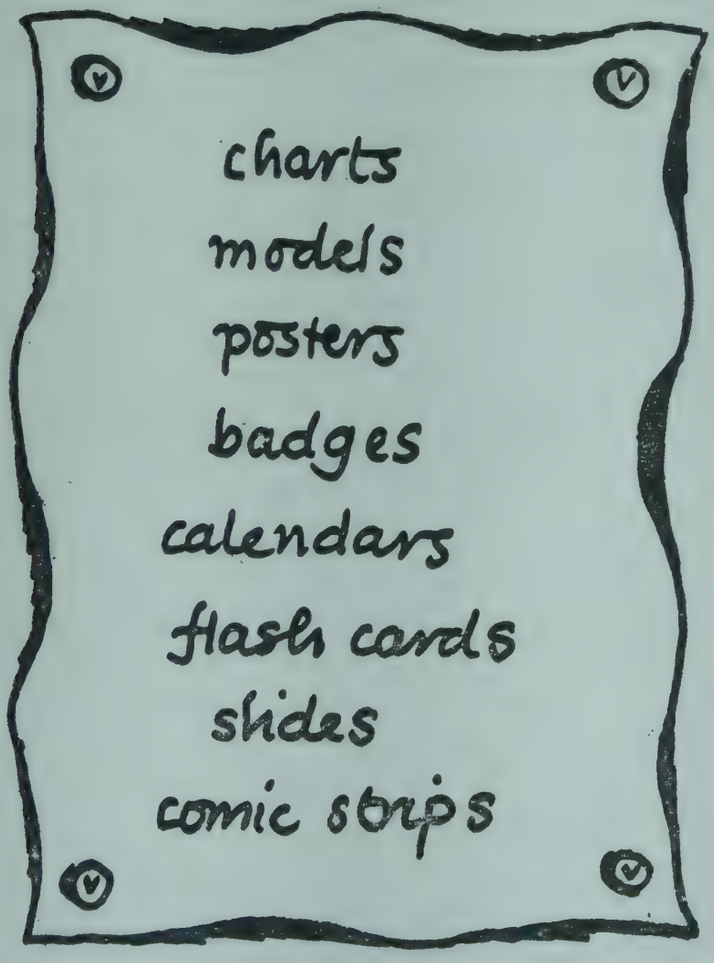
— write a paper for a medical or education journal

— address teachers' meetings, or Indian Academy of Paediatrics meetings

— make a film

— broadcast on AIR or telecast on Doordarshan. Is there a regular 'health' feature?

— get children to make, or make yourself :



— petition the postal authorities to issue a national postage stamp featuring CHILD-to-child

— make sure that these people are kept informed; invite them to your next workshop/meeting :

State Ministers of Health
Youth Work
Women and Child Welfare
Social Welfare
Education
Rural Development

Health Education Officers

Director of School Education

SCERT officers

CHILD-to-child National Committee

— mount an exhibition, or borrow the British Council CHILD-to-child exhibition (enquiries to the National Committee)

— start a newsletter

LIST OF PARTICIPANTS 5

in the Hyderabad Seminar

LIST OF PARTICIPANTS

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"From the solemn gloom of the temple
Children run out to sit in the dust.
God watches them play and forgets the priest."

—Tagore